Justin M. Smith, M.S.
Licensed Marriage and Family Therapist
Licensed Clinical Alcohol and Drug Counselor
3450 E Russell Rd Suite 214, Las Vegas, NV 89120
Phone: (702) 530-8894 Fax: (702) 757-3982

Intake Form

Client Name: ______________________________ D.O.B.: ______________ Gender_________

Partner Name: _____________________________ D.O.B.: ______________ Gender_________

Guardian Name (if applicable): ___________________________ D.O.B.: ________________

Relationship to client: ____________________________

Street Address: ____

City: _____________________________ State: _______________ Zip: _________________________

Home Phone: ____________________________ Ok to leave messages? ☐ Yes ☐ No

Cell Phone: _______________________________ Ok to leave messages? ☐ Yes ☐ No

Ok to text? ☐ Yes ☐ No
PLEASE NOTE THAT TEXTING IS NOT CONSIDERED A SECURE AND CONFIDENTIAL FORM OF COMMUNICATION

Email Address: ______________________________________ Ok to email? ☐ Yes ☐ N0
PLEASE NOTE THAT EMAIL IS NOT CONSIDERED A SECURE AND CONFIDENTIAL FORM OF COMMUNICATION

Please list the names of all others living in the home:

Name: _________________________ Age: _________ Relationship to client: __________________

Name: _________________________ Age: _________ Relationship to client: __________________

Name: _________________________ Age: _________ Relationship to client: __________________

Name: _________________________ Age: _________ Relationship to client: __________________

Name: _________________________ Age: _________ Relationship to client: __________________

Name: _________________________ Age: _________ Relationship to client: __________________

Name: _________________________ Age: _________ Relationship to client: __________________

Emergency Contact Name: ____

Relationship to client: _______________________ Phone Number: _________________________

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Who referred you to me? ____

Ethnic Identity:____________________
How will you be paying for services: ☐ Insurance ☐ Cash ($100 per 45 minutes)

Name of insured: ____________________________ SSN: ___________________

Insurance Name: ____

Subscriber ID #: ____________________ Group #: ________________________

Start Date: _____________________ Expiration Date: ______________________

Employer who insurance is through: _____________________________________

Street Address: ____

City: _______________________ State: ___________ ZIP: ___________________

PLEASE NOTE THAT THIS IS NOT A GUARANTEE OF COVERAGE.

Please check the appropriate box:

☐ I Agree to have my insurance charged and to pay the designated co-payment

By signing below, I understand that by choosing to have my insurance billed I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits/medical benefits to Justin M. Smith.

Signature: _______________________________________

☐ I do not want my insurance billed. I, therefore agree to pay the cash price of $100 per 45-minute session.

☐ I do not want my insurance billed. I, therefore agree to buy 3, 45-minute sessions for $250

☐ I do not want my insurance billed. I, therefore agree to buy 5, 45-minute sessions for $400

Education (Highest grade completed): ____________________________

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Occupation: ___________________________ Employer/School: ______________________________

Length of time with this employer: _____________ Shift worked: _______________________

Date of last medical examination: _________ Name of Doctor: __________________________

Would you sign a release to allow me to speak with your doctor? ☐ Yes ☐ No

Please list any chronic diseases, such as diabetes, epilepsy, TB etc. that you have:
____
____

Are you disabled, on disability, or do you have any physical problems? If so, please list: ____
____

Please briefly describe why you are seeking services at this time:
____
____
____
____
____

Have you ever received a mental health diagnosis? ☐ Yes ☐ No

If yes, what have you been diagnosed with?___________________________________
____

Please list any medications you are currently prescribed:

Name: _______________ Dosage: _________ Reason: ________________________
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Name: _______________ Dosage: _________ Reason: ________________________
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Please check the appropriate boxes below indicating the symptoms you are currently experiencing:

☐ Anxiety ☐ Obsessive Thoughts ☐ Panic Attacks

☐ Excessive Fear ☐ Hypervigilance ☐ Trauma

☐ Nightmares ☐ Insomnia ☐ Irritability

☐ Impulsivity ☐ Aggression ☐ Depression

☐ Low Energy ☐ Poor Concentration ☐ Grief/Loss

☐ Distractibility ☐ Suicidal Thoughts ☐ Chronic Pain

☐ Academic Problems ☐ Sexual Dysfunction ☐ Suspiciousness

☐ Hallucinations ☐ Bizarre Behavior ☐ Delusions

☐ Poor Social Skills ☐ Eating Disorder ☐ Divorce

☐ Substance Abuse ☐ Domestic Violence ☐ Marital Issues

Are you currently or have you ever been in therapy? ☐ Yes ☐ No If “yes” would you sign a release to allow me to communicate with your therapist? ☐ Yes ☐ No

Acknowledgement

By signing below, I acknowledge that I have completed the above form to the honestly and to the best of my ability.

Signed: ______________________________ ______________
Client or parent/guardian Date

Signed: ______________________________ ______________
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Signed: ____ ___________________
Justin M. Smith Date